

Foetal Experience

By Clare Allen

The life of a man starts while he is still in the uterus, where he can experience emotions both painful and pleasant which will ultimately condition his state of mind.

The State of Mind That Affects the Foetus,
Dr F J Master

Recent research suggests that pregnant 9/11 survivors who developed post-traumatic stress disorder passed its symptoms to their unborn children. If baseline stress levels are developed in the womb and our response to stress is based on the nature of our birth, how does this affect homeopathic case-taking and prescribing?

This article looks at how the experiences of the foetus (in the womb and during traumatic delivery) affect the subsequent behaviour and development of the individual, and explores how a deeper understanding of these issues can help with case-taking and analysis. The details of a patient's birth are generally accepted as an important part of the case for babies and young children, but I would like to take this further, by presenting some of the available research in this area, and exploring its relevance to the homeopathic process.

My reasons for wanting to take these issues into account from the baby's point of view began very personally. I had two very different but both very traumatic deliveries myself, and believe I have seen first-hand how this subsequently affects the growing child. In a 'natural' delivery, hormones secreted by the foetus trigger labour; but so often this natural process is interfered with, for example by induction. It is thought that infants with certain conditions such as autism, may not secrete the correct hormones, and this can cause difficult deliveries. As a baby cannot fully articulate its pains and fears, I felt that a much deeper understanding is required if, as homeopaths, we are to be able successfully to recognise and treat those individuals whose pre-natal or birth experiences have had lasting effects on their development. We need to be able to recognise those patients who may be 'stuck' at this fundamental point in their lives, as indeed they may have been stuck in the birth canal.

Last year I had a conversation with a friend and fellow student as we were watching our children. We realised that the children in front of us, without exception, displayed echoes within their innate personalities of the way they had been born. Where labour had been fast and furious, the child was charging through life doing exactly as she pleased, and with a temper that is a sight to behold. Where labour had been slow and protracted, the children were hanging back, checking out the situation before feeling ready to join in. Where the

birth was induced, despite generally normal developmental milestones, the children never seem to be quite ready to face the next step: nursery, potty training or school. The child who was injured during birth is physically fearless, but completely terrified of the dark and of being alone. It is also possible however, that the reverse is true, that the nature of the birth was the first reflection of their individual personalities.

I realise that this may possibly present as a somewhat sentimental view, and of course is only representative of a small handful of children. However, as birth is such a sudden and complete change in the only life the foetus has ever known, I feel the process must have the potential to exert a profound and lasting influence on the individual.

Foetal Memory and Awareness

Until relatively recently, it has been widely believed that the newborn baby did not possess a functioning memory, rather that memory developed over the months and years following birth. However, research on attachment, breastfeeding and recognition suggests that a newborn baby does in fact possess a functioning memory, and because it is very unlikely that this memory is in some way triggered during birth, it is therefore now generally accepted that memory begins pre-natally.

New research is beginning to demonstrate just how critical the period in the womb can be with regard to the long-term health of the individual. Foetal responses to physical stimulation and environmental toxicity are well-documented fields, but what of the effect of the mental and emotional state of the mother during pregnancy?

A UK report published in 2002 examined the hypothesis that ante-natal anxiety (of the mother) predicts child behavioural/emotional problems independently of post-natal depression. In the study, 7,144 women reported their mood at various points throughout their pregnancy and the post-natal period. Smoking, alcohol use, birth

weight, maternal age, sex and socio-economic status were all taken into account. The children were assessed behaviourally and emotionally at the age of four. The study concluded that ante-natal anxiety and post-natal depression represent separate risks for behavioural and emotional problems in children, and act in an additive manner.

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The following is from a television interview with Dr Vivienne Glover from Queen Charlotte Hospital: The main stress hormone, cortisol, has been shown to cross the placenta; enough can get through to actually double foetal levels. This has the effect of resetting a number of receptors in the foetal brain, so the response to stress in later life is altered. Circumstances around delivery are also believed to have an effect on later stress levels. Caesarean birth with no labour is the least stressful for the baby; a normal vaginal delivery is moderately stressful, and forceps or assisted deliveries are very stressful indeed. Dr Glover measured the increase in cortisol production in babies during the stress of routine vaccinations at eight weeks old. Babies who had been born by caesarean had a very low response, those born by normal vaginal delivery had an intermediate response, and those born by forceps or ventouse had the highest response. The hypothesis is that baseline stress levels are established in the womb and then our response to stress is determined by the nature of the birth.

More recently, the *Journal of Clinical Endocrinology and Metabolism* published details of a study which shows that pregnant women present during the September 11th World Trade Centre collapse have passed on markers of post traumatic stress disorder (PTSD) to their unborn babies. Researchers from Mount Sinai School of Medicine and the University of Edinburgh tested salivary cortisol levels in 38 women and their one-year-old babies. Mothers who experienced PTSD in response to the terrorist attacks had lower cortisol levels than women who did not develop PTSD. The study also found that the babies of mothers who developed PTSD had significantly lower cortisol levels than babies of women who developed only minimal PTSD symptoms after 9/11. These findings further strengthen the evidence for in-utero risk factors for the later development of adult mental or physical disorders. Lower cortisol levels in relation to maternal PTSD were most evident in babies born to women who were in their third trimester of pregnancy on 9/11.

Research into foetal life is a popular field. Michel Odent is a leading pioneer and is currently working to create a data bank (www.birthworks.org/primalhealth) so that studies can be correlated. It is his belief that the quality of foetal life has a great influence on health in later life, but he recognises that it is this 'quality' that is so difficult to pinpoint and measure.

Harry van der Zee, author of *Miasms in Labour*, believes that traumatic events during pregnancy are of great importance in case analysis in both children and adults. He explains that due to the intensity of the birth experience, the symptoms of the mother tend to be very reliable and strong, and he urges that in case taking, even if a mother says that the birth was fine, not to

leave it at that, but to ask for more details. He talks about listening carefully to the patients' language, as certain phrases may provide clues to ongoing reactions to birth trauma. For example, phrases such as: *there's no way back; I can't get started; I don't know which way to go; I can't see a way out; I feel crushed; I'm beating my head against a brick wall.* Although this sort of language would certainly be interesting if it formed a general pattern, I feel that as it is in everyday use, it could be misleading if taken too literally.

Susceptibility

Susceptibility of the individual obviously plays a part in the birth process. A foetus will have an innate inherited susceptibility, but I think it is reasonable to suppose that events both prior to and during birth could lead to acquired susceptibility. For example, Baby C was born in the face presentation in May 2000 following induction of labour. On delivery, he was healthy apart from severe facial trauma. C developed meningitis at 12 weeks old, but recovered well. For the next six months there was a history of painful ear infections followed by a diagnosis of glue ear. He also had a habit of sitting up and persistently banging his head against his cot. Subsequent development was normal, except for a tendency to accidents, particularly involving his head. I believe that this child may well be displaying an altered state of susceptibility brought about by the nature of his birth. Does a relatively straightforward delivery actually satisfy susceptibility in some way?

According to Vithoulkas, the vital force reacts instantly to any external stimuli, but it is only if the stimulus is stronger than the vital force that it causes symptoms to develop. He also writes of the 'latent period' before symptoms develop. This is described conventionally as the incubation period of a disease. Vithoulkas explains that if an individual did not have a susceptibility to the microorganism, then it would not be able to thrive in the body. We also need to consider the effects of emotional stress on the foetus, as this may lead to an extended latent period and then a manifestation of chronic disease months later. I feel that combined scientific research and homeopathic experience provides grounding as to why pre-natal and birth experiences may be so important when analysing the cases of infants and children.

Birth Memories

It is gradually becoming accepted that some individuals can remember being born. It is thought that oxytocin, the hormone that induces uterine contractions, may have an amnesiac effect, with the result that memories of birth are rare. Dr David Cheek conducted a study back in the 1970's, taking four young men and women whom he had delivered, and putting them under hypnosis. He then asked them to describe how their heads had been positioned at birth. There was no way his subjects could have known this information, but in every case the answers were correct, and the medical records confirmed what the subject remembered.

The significance of this study is huge. If a person is capable of remembering the position in which he was born, what about memories of being stuck in the birth canal or being forced out with forceps? Surely, even if such profound memories are not in the day-to-day consciousness of an individual, they will be present somewhere in the deep subconscious and therefore have influence on some level.

The Acute Miasm

The situation of traumatic birth is similar to Rajan Sankaran's description of the acute miasm.¹⁰ He writes that there is the feeling of 'a strong threat from the outside world'; there is a sense of acute threat and the feeling can be overwhelming alarm. I think that this can be likened to the process of labour and birth, probably for both mother and child. Sankaran states that this miasm is found more often in babies and children, as it is at this time that situations from the outside are the most threatening. However, he also says that it can be recognised in adults who display instinctive, almost childlike reactions. Perhaps another reason for this miasm being more prevalent in the very young is that it can be indicative of an ongoing reaction to birth, whereas in adults, this state would probably be largely compensated.

The Baby's Experience of Birth

'To be born is to suffer. Birth is pain. For the woman, as we all know, and for the child, as we have forgotten' Frederic Leboyer

Midwives throughout history have learned their skill as it has been passed down to them. However, as modern medicine gained legitimacy and power toward the end of the 19th century there was a gradual shift in favour of obstetrics in a hospital setting. By the early 20th century, it appears that birth had evolved from a physiological event into a medical procedure.

More recently there have been shifts back towards more natural childbirth, supplemented with the technology and know-how of modern medicine. Frederic Leboyer is a French doctor who wrote a revolutionary book in 1974 called *Birth Without Violence*, and was directly responsible for creating the awareness in maternity wards of the intact functioning of the senses of the newborn baby.

While researching this subject, I was aware that I wanted to look at the experience of birth from the perspective of the baby. I had expected to find this a somewhat difficult topic to research, as surely it must be largely conjecture. I also expected the focus of what the baby experienced to be pain. I was wrong on both counts.

The groundbreaking French obstetricians Frederic Leboyer and Michel Odent have both written extensively on this subject, and have certainly convinced me that what they have written is far from mere conjecture. Although the baby undoubtedly does feel some pain, the overwhelming emotions of birth would appear to be **shock** and **fear**.

One of the hormonal reactions to such emotions would be an increase in adrenalin. It would be reasonable to assume that adrenalin plays a large part in triggering various functions of the newborn baby. In studies done on lambs,¹¹ rising concentrations of adrenalin during labour

positively correlate with progressive re-absorption of liquid in the foetal lungs and the production of surfactant. Similar changes in humans are evident from studies comparing the lung function of babies born vaginally to those born by caesarean section. From measurements taken at 30 and 120 minutes after birth, tidal volume, breaths per minute and dynamic lung compliance were found to be significantly lower in the caesarean section group. This indicates that higher levels of surfactant and a faster elimination of lung liquid occur in response to adrenalin and the other stimulatory influences of labour. Therefore, when taking the case of infants, young children or, indeed, adults with chronic chest complaints, it may be very useful to ascertain whether the delivery was by caesarean, or inordinately fast.

Consequences of Foetal Experience

Even the most straightforward deliveries are extremely hard work for both mother and baby. But as Leboyer and Odent so zealously advocate, surely if a traumatised infant is quickly comforted and its needs understood and met, there is the maximum chance of limiting any long-term damage.

Cranial osteopathy is often suggested after a difficult birth, and rightly so. There is also a strong argument for advocating homeopathic treatment as soon after delivery as possible, to minimise any long-term psychological as well as physiological effects of traumatic birth.

Michel Odent is of the opinion that the way the body learns to respond during the 'primal period', i.e. pre-natally and during the first year of life, cannot be undone.¹¹ However, I would have to argue, that by targeting the dynamic plane of an individual with suitable homeopathic medicines, I see no reason why such changes cannot be effected.

One of the functions of Michel Odent's Primal Health Research Centre has been to compile a database of all studies undertaken in this regard. This database can be found at www.birthworks.org/primalhealth.

A number of these studies have been concerned with foetal experience and subsequent health issues. I have included the following examples to demonstrate the extraordinary diversity of issues that can be linked with birth trauma:

A study in Finland in 2000 concluded that there was a higher risk of asthma in children who were administered special procedures at birth, i.e. caesarean, forceps, ventouse. The risk also increased in children with a lower Apgar score.

A study in Ireland in 1992 looked at the background of schizophrenic patients. Those with schizophrenia were more likely than the controls to have experienced at least one obstetric complication. Foetal distress was the only complication to occur to significant individual excess. Interestingly, they go on to remark that

these obstetric complications may be secondary to yet earlier events. There is increasing evidence to suggest that anomalies develop prenatally in schizophrenia, and that these individuals are already more fragile when labour begins.

In Sweden in 1999 the records of 781 girls between the ages of 10 and 21 who had been diagnosed with anorexia were examined, and it was found that both a cephalhaematoma, which is a sign of a very traumatic birth, and vaginal instrumental delivery, i.e. forceps or ventouse, are both risk factors but a caesarean is not. An increased risk of developing anorexia was also found among girls born before 32 weeks' gestation.

Dr F. J. Master¹⁴ states that we all have a state of mind consisting of a group of symptoms. However, if we find our reactions to situations disproportionate to what would normally be considered reasonable, then it is likely that we are in what he terms an 'artificial state'. He also believes that the exciting cause is often a terrible fright in childhood or infancy. Therefore, where there has been birth trauma, there may also be an artificial state that has existed for the patient since the time of their birth, or perhaps before. Dr Master also believes that the mother's state can also be directly transmitted to the foetus, and often such individuals will require the remedy that the mother needed during her pregnancy.

Fear and the child are born together
Frederic Leboyer

Stramonium and Opium

Stramonium and *Opium* are familiar remedies, both often indicated in children and where there has been a difficult birth. *Stramonium* has feelings of terror, being unprotected, abandoned, and left alone in a terrifying place. There is also anxiety when hearing running water or going through a tunnel, resulting in a sensation of suffocation. *Stramonium* shares with *Opium* the delusion that parts of their body are too large. This provides an analogy to the foetal experience. At first, it would not encounter boundaries, but as it grew, it would begin to feel the walls of the uterus pushing back against it. During the squeeze down the birth canal, the baby would be more aware than ever of the size of his or her body. *Stramonium* is a remedy for being stuck in the birth canal and it seems also to be a remedy for being stuck emotionally at the time of one's birth.

In an *Opium* state, the reaction is flight rather than fight, but usually the flight involves withdrawal into an inner world; a newborn infant cannot withdraw in any other way. The characteristic *Opium* mental state is one of withdrawal and stupor; coma is part of its picture. For the *Opium* patient, fear or fright is a strong causation, and the fear of the fright remains, as if they are unable to cut loose (or perhaps they do not want to be cut loose, in the case of the newborn and the umbilical cord). The state can be likened to that of a coma, or of having almost died; the connection between body and soul is loose, and feelings are numb and dominated by fear. Vermeulen believes that *Opium* is the 'most important and frequently indicated remedy for the treatment of harmful influences and their consequences during pregnancy.'¹⁵ Within the withdrawal, there is a sense as if one were resting in a pleasant nothingness, which could be compared to the experience of the foetus in the womb.

Reversed peristalsis together with constipation is also part of the *Opium* picture, and both can produce symptoms of reflux. Grandgeorge considers that where labour is artificially induced, the baby may be more prone to chronic gastric reflux.¹⁶ He goes on to explain that when the baby is in the womb, peristaltic movements are directed upward to enable the foetus to regurgitate amniotic fluid, but some babies do not change the direction of peristalsis after birth, resulting in the reflux.

Conclusion

Pre-natal and birth experiences can have a profound and lasting effect on the individual.

When prescribing constitutionally, it is always the aim to take into account the largest possible totality. I strongly believe that certainly in the cases of infants and young children, this totality must include a detailed understanding of the mother's state of mind during pregnancy, and the birth circumstances. I think that the younger the patient, the more important this information can be; after all, such patients will often provide us with little else to go on, and it is a relatively large and significant part of their existence.

Furthermore, I feel that although this information is perhaps of more value generally when taking the cases of infants and children, it should not be discounted as a tool in adult cases where there is evidence of very 'stuck' behaviour dating back to a young age. I would also say that where a birth story does not seem to match up to a case history, then far from being unhelpful, this is an indication of the level of health of the individual, and his or her susceptibility. Some babies will be affected by minor complications indicating perhaps great sensitivity, while others may appear not to have had a problem with even the most difficult deliveries. As always, each child should be considered as a unique individual.

References

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